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ABSTRACT

Before the mid-1960's the Federal role in health care was extremely limited, but technological breakthroughs, the new importance of hospitals, and the recognition that the poor and elderly have been underserved prompted Congress to pass the Medicare and Medicaid package in 1966. Since then the Federal share of the health care dollar has risen by more than 60 percent. Soaring hospital costs resulted from disconnected and overlapping delivery systems and the tendency of the legislation to bias coverage toward inpatient care. The Health Maintenance Organization (HMO) bill provides a more balanced approach with a variety of services, outpatient care, and special facilities for a flat yearly fee. Since private health insurance is unprofitable, consideration is being given to a national insurance program to provide effective coordination between organized modes of health care delivery. It would consist of two segments--the larger paid by workers and employers and the smaller subsidized by the government to aid the poor. A carefully considered plan must be pressed to completion and promptly considered in Congress. (MS)

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STATEMENT BY CONGRESSMAN JOHN B. ANDERSON OF ILLINOIS

"THE POLITICS OF HEALTH CARE"

BEOFRE NORTHERN ILLINOIS UNIVERSITY STUDENT NURSES ORGANIZATION

LECTURE SERIES ON HEALTH CARE AND HUMAN RIGHTS

DEKALB, ILLINOIS

NOVEMBER 7, 1973

I MUST ADMIT I APPROACH MY TOPIC WITH SOME AWE THIS EVENING. THE POLITICS OF HEALTH CARE IS NO SMALL SUBJECT. IT TOUCHES ALL OF US AND IT CARRIES WITH IT TODAY PROFOUND IMPLICATIONS FOR THE FUTURE SHAPE OF OUR HEALTH CARE DELIVERY SYSTEM AS WELL AS THE LIKELIHOOD OF MASSIVE FEDERAL FUNDING TO MEET THE COSTLY HEALTH CARE NEEDS OF MILLIONS OF AMERICANS.

IT IS INTERESTING TO NOTE, HOWEVER, THAT PRESENT PROSPECTS IN THIS AREA AND TODAY'S LEGISLATIVE GOALS WERE HARDLY DISCUSSED ONLY A DECADE AGO. BEFORE THE MID-1960'S THE FEDERAL ROLE IN HEALTH CARE WAS EXTREMELY LIMITED, NO COMPREHENSIVE HEALTH CARE LEGISLATION HAD BEEN ENACTED, AND DEBATE IN CONGRESS FOCUSED NOT ON SPECIFIC PROPOSALS BUT ON GENERAL THEORIES AND PRINCIPLES WHICH WERE STILL UNSETTLED. STATES' RIGHTS ADVOCATES AND THE AMERICAN MEDICAL ASSOCIATION ADAMANTLY OPPOSED ANY FEDERAL INTERVENTION IN WHAT THEY CALLED THE LOCAL DOMAIN WHILE NEW DEAL LIBERALS WERE TENTATIVELY VOICING A NEW INALIENABLE RIGHT FOR AMERICAN CITIZENS, "THE RIGHT TO HEALTH."

IN LOOKING BACK, I CAN'T HELP OBSERVING A SINGLE CONTRAST BETWEEN THE PRESENT — THIS EVENING IN PARTICULAR — AND THE RECENT PAST WHICH I HAVE JUST DESCRIBED. AS LATE AS 1960 THERE MUST HAVE BEEN VERY FEW

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UNITED STATES CONGRESSMEN EXPRESSING THEIR VIEWS ON THE POLITICS OF HEALTH CARE BEFORE GROUPS OF STUDENT NURSES. IN SPITE OF THE LACK OF HISTORICAL PRECEDENT, I PROPOSE TO EXPLORE TONIGHT A NUMBER OF ISSUES WHICH PROBABLY CONCERN YOU MOST DIRECTLY -- RECENT HEALTH CARE LEGISLATION, ITS EFFECTS ON HEALTH CARE DELIVERY, CURRENT PROPOSALS, AND WHAT WE CAN EXPECT IN THE WAY OF FUTURE LEGISLATIVE ACTION.

1966 WAS A LANDMARK YEAR FOR HEALTH LEGISLATION. A NUMBER OF IMPORTANT TECHNOLOGICAL, SOCIAL AND POLITICAL PRESSURES HAD MOUNTED AND CONVERGED, PROMPTING PASSAGE IN CONGRESS OF THE MOST IMPORTANT PIECE OF FEDERAL HEALTH LEGISLATION IN THE NATION'S HISTORY -- THE MEDICARE AND MEDICAID PACKAGE. THE FOUNDATIONS OF ACCEPTED MEDICAL PRACTICE HAD BEEN DRASTICALLY CHANGED BY TECHNOLOGICAL BREAKTHROUGHS. AS LABORATORY TESTS, X-RAYS, AND ELECTROCARDIOGRAPHS GAINED INCREASING USE, THE PRACTITIONER'S BLACK BAG, STETHOSCOPE AND EPSOM SALTS BECAME MERELY THE FIRST LINE OF MEDICAL DEFENSE. HOSPITALS TOOK ON A NEW IMPORTANCE IN HEALTH CARE DELIVERY AND THEIR INCREASINGLY EFFECTIVE BUT COSTLY SERVICES WERE SOUGHT BY MORE OF THE SICK THAN EVER.

AT THE SAME TIME, AN AWARENESS HAD DEVELOPED AMONG AMERICANS THAT TWO GROUPS, THE POOR AND THE ELDERLY, WERE BEING TRAGICALLY UNDERSERVED. BY THE MID-1960'S, THESE DEVELOPMENTS COALESCED WITH POLITICAL EVENTS AND WITH THE BEGINNING OF THE MOVEMENT TOWARD PRESIDENT JOHNSON'S "GREAT SOCIETY" LEGISLATION. THUS, THE SCENE WAS SET FOR ENACTMENT OF SWEEPING SOCIAL PROGRAMS.

THE LEGISLATIVE RESULT IN THE HEALTH ARENA WAS MEDICARE AND MEDICAID WHICH PROVIDED VOLUNTARY HEALTH INSURANCE FOR THE AGED UNDER SOCIAL

SECURITY AND EXTENDED FEDERAL HEALTH BENEFITS TO THE INDIGENT. SUPPORTERS OF THIS PROGRAM CLAIMED THEY HAD ACHIEVED "A GIANT STRIDE FORWARD" WHILE OPPONENTS FEARED ITS INFLATIONARY EFFECTS UPON THE HEALTH CARE INDUSTRY. BOTH SIDES AGREED, HOWEVER, THAT THE ENACTMENT OF MEDICARE AND MEDICAID REPRESENTED AN IRREVOCABLE COMMITMENT FOR THE FEDERAL GOVERNMENT IN THE FINANCING OF INDIVIDUAL HEALTH CARE EXPENDITURES.

OVER A THREE YEAR PERIOD, FROM 1966 TO 1969, THE FEDERAL SHARE OF THE HEALTH CARE DOLLAR ROSE BY MORE THAN 60 PERCENT. BEFORE LONG IT BECAME CLEAR THAT THE FEDERAL GOVERNMENT HAD TAKEN ON A FINANCIAL RESPONSIBILITY OF TREMENDOUS PROPORTIONS WHICH WOULD ONLY GROW AS THE OVERALL POPULATION EXPANDED AND AS UNPRECEDENTED DEMAND FOR MORE AND BETTER SERVICES INCREASED. DISTRESSING FOR THE NATION'S HEALTH CARE COMSUMERS AND SURPRISING FOR THOSE EARLY ENTHUSIASTS OF MEDICARE AND MEDICAID LEGISLATION WAS THE UNFORESEEN RESULT WHICH PERSISTS AS THE MOST PRESSING HEALTH CARE PROBLEM TODAY: SOARING HOSPITALS COSTS. AS MANY MID-60'S CRITICS HAD PREDICTED, MASSIVE INFLATIONARY PRESSURES CLOSED IN ON THE HEALTH CARE INDUSTRY.

ALTHOUGH SOPHISTICATED NEW EQUIPMENT, NECESSARY WAGE INCREASES FOR UNDERPAID MEDICAL PERSONNEL, AND GENERAL ECONOMIC INFLATION ACCOUNTED FOR SOME OF THE OVERALL PRICE RISE IN THE HEALTH CARE SECTOR, HOSPITAL COSTS EXPERIENCED THE BIGGEST INCREASE -- A JUMP WHICH COULD NOT BE EXPLAINED BY THESE FACTORS ALONE. IT SOON BECAME EVIDENT THAT DEFICIENCIES IN THE DESIGN OF MEDICARE AND MEDICAID LEGISLATION WERE PLAYING A MAJOR ROLE IN FORCING THE UPWARD SPIRAL OF HOSPITAL PRICES.

WITH SUBSIDIZED MEDICAL PAYMENTS FOR THE AGED AND POOR, MEDICARE AND MEDICAID HAD INTRODUCED WHOLE NEW SEGMENTS OF THE POPULATION TO A HEALTH CARE DELIVERY SYSTEM WHICH WAS TOTALLY UNPREPARED TO HANDLE THE

NEW LOAD. BADLY IN NEED OF RATIONAL RESTRUCTURING, THE DISCONNECTED AND OVERLAPPING SYSTEM OF SEPARATE LABORATORY FACILITIES, COMPETING HOSPITALS, AND ISOLATED PRIVATE PRACTICES WERE UNABLE TO MEET THE NEW DEMANDS WHICH MEDICARE AND MEDICAID PATIENTS PLACED UPON THEM.

I WOULD LIKE TO BRIEFLY DESCRIBE A FEW OF THE COMPLEX PROBLEMS ASSOCIATED WITH AN UNSTRUCTURED DELIVERY SYSTEM WHICH HAMPERED EFFICIENT PERFORMANCE. WHEN SEPARATE AND DISCONNECTED HEALTH FACILITIES EXIST WITHIN ONE COMMUNITY, PATIENTS ARE OFTEN REFERRED WITHOUT ADEQUATE COMMUNICATION. PROFESSIONAL EFFORTS ARE THEREFORE NEEDLESSLY DUPLICATED, LABORATORY TESTS REPEATED, AND THE PATIENT HOPELESSLY CONFUSED BY INCONSISTENT AND IMPERSONAL CARE. NOW THAT METROPOLITAN HOSPITALS CAN PASS ON MANY OF THEIR COSTS TO THE FEDERAL GOVERNMENT OR PRIVATE INSURANCE COMPANIES, THEY FREQUENTLY INVEST IN UNNECESSARY EQUIPMENT ALREADY AVAILABLE AT NEIGHBORING HOSPITALS. FINALLY, SINCE HOSPITAL COSTS HAVE LITTLE DIRECT IMPACT ON PARTICIPANTS IN THE NEW HEALTH CARE RELATIONSHIP, PATIENTS WHO NEED NOT PAY FROM THEIR OWN POCKETS MAY BE PROVIDED WITH MARGINAL SERVICES OF DUBIOUS VALUE. CARE IS THUS DRAINED FROM OTHER PATIENTS IN GREATER NEED.

ANOTHER OVERSIGHT IN THE ORIGINAL MEDICARE AND MEDICAID LEGISLATION FURTHER EXACERBATED DEMANDS FOR HOSPITAL SERVICES. COVERAGE WAS BIASED TOWARD INPATIENT HOSPITAL CARE. SINCE LITTLE OR NO SUBSIDIES WERE PROVIDED FOR OUTPATIENT OR AMBULATORY SERVICES, MANY MORE PATIENTS, WHETHER OR NOT THEY NEEDED 24-HOUR CARE, WERE FUNNELLED INTO ALREADY OVERLOADED HOSPITALS.

THESE UNFORTUNATE DEVELOPMENTS NOT ONLY ESCALATED HOSPITAL COSTS BUT THEY IMPERILLED THE VERY GOAL THAT MEDICARE AND MEDICAID PROGRAMS HAD SET OUT TO ACHIEVE. FOR THE FACT REMAINED THAT MANY OF THE POOR AND THE ELDERLY WERE STILL BEING DENIED ADEQUATE CARE.

AS THESE PROBLEMS SURFACED, A CRISIS ATMOSPHERE DEVELOPED IN CONGRESS. A VARIETY OF EXPENSIVE AND LOUDLY ACCLAIMED PROPOSALS FOR RIGHTING THE BALANCE WERE AIRED BY THOSE WHO SAW ONLY THE APPARENT PROBLEM — A SEVERE SHORTAGE OF HEALTH CARE RESOURCES. ALTHOUGH THE TIME WAS RIPE FOR SERIOUS CONSIDERATION OF THE FUNDAMENTAL ISSUES, NEW LEGISLATIVE ACTION ADDRESSED ITSELF TO STOP-GAP MEASURES, A SHORING UP OF THE LABOR FORCE AND THE CONTRUCTION OF NEW HOSPITALS. CONGRESS CHOSE TO APPROPRIATE MONIES FOR EXPANDING AND INCREASING THE TRAINING PROGRAMS FOR HOSPITAL STAFF -- NURSES, DOCTORS AND TECHNICIANS — AS WELL AS FOR ASSISTANCE TO STATES IN CONSTRUCTING NEW HOSPITALS. WHILE THIS CERTAINLY HELPED MEET PRESSING SHORTAGES, ATTENTION HAD BEEN DIVERTED FROM BASIC REFORM, AND THE TWO STUBBORN PROBLEMS REMAINED: HOSPITAL COSTS ROSE EVEN HIGHER AND THE INEFFICIENT DELIVERY SYSTEM CONTINUED TO LOAD MORE DEMAND ON HOSPITALS.

THE PERSISTENCE OF THESE PROBLEMS HELPED TO CREATE A NEW AWARENESS OF THE VALUE OF A BALANCED APPROACH TO HEALTH CARE LEGISLATION. THIS HAS BEEN REFLECTED IN THE LEGISLATION SINCE INTRODUCED IN CONGRESS.

ONE IMPORTANT EXAMPLE IS THE HEALTH MAINTENANCE ORGANIZATION (HMO) BILL WHICH PASSED THE HOUSE TWO MONTHS AGO. IT PROVIDES FEDERAL FUNDING FOR A NUMBER OF PREPAID GROUP HEALTH PLANS, FALLING UNDER THE CATEGORY OF THE POPULAR TERM, HMO'S. THE ATTRACTIVE FEATURES OF HMO'S ARE WELL-KNOWN. A VARIETY OF SERVICES, OUTPATIENT CARE, A NUMBER OF MEDICAL SPECIAL-

TIES, HOSPITAL CENTERS, AND LABORATORY FACILITIES ARE GROUPED INTO A SINGLE ORGANIZATION WHICH CHARGES INDIVIDUAL PATIENTS A FLAT YEARLY MEMBERSHIP FEE. HMO ADVOCATES MAINTAIN THAT THIS ANNUAL PAYMENT SYSTEM AND THE CONVENIENT STRUCTURE OF HMO'S ENCOURAGE COST CONTROL AND PROMOTE PREVENTIVE CARE.

THE GROUP HEALTH ORGANIZATION, A PLAN FOR FEDERAL EMPLOYEES IN WASHINGTON, DREW A GRAPHIC PICTURE OF THE POTENTIAL BENEFITS OF HMO'S IN TESTIMONY BEFORE CONGRESS. IN A HYPOTHETICAL SITUATION, A PATIENT WOULD PAY THE HMO TO WHICH HE BELONGS A MONTHLY PREMIUM THAT COVERS A BROAD RANGE OF SERVICES WITHOUT LIMITS ON COSTS OR DURATION. IF THE PATIENT DEVELOPS SEVERE LEG PAINS, FOR EXAMPLE, HE WOULD FIRST GO TO HIS HMO MEDICAL CENTER FOR AN APPOINTMENT WITH HIS DOCTOR, ONE OF SEVERAL STAFF INTERNISTS. HIS DOCTOR, SUSPECTING PERHAPS AN INFLAMED SPINAL DISC (I HOPE THIS AUDIENCE WILL EXCUSE ANY FAULTY DIAGNOSES I MIGHT MAKE ALONG THE WAY HERE.) , HE REFERS THE PATIENT TO AN ORTHOPEDIC SURGEON ON THE STAFF. THE SURGEON WOULD THEN PUT HIM IN A LOCAL HOSPITAL FOR TRACTION TO TRY TO RELIEVE THE INFLAMMATION. UNDER THIS SCENARIO, THE TREATMENT DOES NOT WORK AND THE PATIENT IS THEN REFERRED TO A STAFF NEURO-SURGEON. THE NEURO-SURGEON, AFTER MAKING SOME LABORATORY TESTS, RECOMMENDS SURGERY TO REMOVE WHAT HE HAS DIAGNOSED AS A RUPTURED DISC. AFTER THE OPERATION AND SEVERAL SESSIONS WITH THE HMO'S PHYSICAL THERAPIST, THE PATIENT HOPEFULLY RECOVERS COMPLETELY.

WITHOUT HMO COVERAGE, OUR HYPOTHETICAL PATIENT MIGHT GET SEPARATE BILLS FROM SEVERAL DOCTORS OR SURGEONS, THE HOSPITAL, A PHYSICAL THERAPIST AND A LABORATORY DEPARTMENT. HIS PRIVATE HEALTH INSURANCE MIGHT COVER ALL,

PART OR NONE OF THE BILLS DEPENDING ON HIS POLICY. UNDER A LIBERAL HMO COVERAGE PLAN, HOWEVER, THE HMO WOULD PICK UP THE ENTIRE COST OF HIS ILLNESS.

SUCH HYPOTHETICAL SUCCESS STORIES ABOUNDED WHEN THE ORIGINAL HMO BILL WAS INTRODUCED. THIS BILL WOULD HAVE COMMITTED THE FEDERAL GOVERNMENT TO THE FULL-SCALE DEVELOPMENT OF A NATIONWIDE HMO PROGRAM WITH MASSIVE FEDERAL FUNDING AND AN EMPHASIS ON LARGE, COMPLEX ORGANIZATIONS. HOWEVER, THIS TIME CONGRESS, CHASTENED BY ITS EXPERIENCE WITH MEDICARE, LOOKED BEFORE IT LEAPED.

ABOUT 500 HMO-TYPE GROUP PRACTICE ORGANIZATIONS ARE ALREADY IN EXISTENCE. SOME ARE LINKED TO EMPLOYEE-EMPLOYER COST-SHARING PLANS, OTHERS TO PRIVATE INSURANCE COMPANIES AND YET OTHERS ARE ASSISTED BY FEDERAL FUNDS. DESPITE THE OFTEN REPEATED CLAIMS THAT HMO'S PROMOTE EFFICIENCY AND REDUCE OVER-UTILIZATION OF SERVICES, CRITICS POINTED OUT THAT THE STATISTICS USED TO SUPPORT THESE CLAIMS DO NOT ACCOUNT FOR SERVICES PROVIDED OUTSIDE OF THE HMO. YET SOME SURVEYS SHOW THAT UP TO 40 PERCENT OF PHYSICIAN SERVICES USED BY HMO ENROLLEES ARE OBTAINED OUTSIDE OF THE PLAN.

CRITICS ALSO MAINTAIN THAT HMO'S MAY ACTUALLY RESULT IN A SERIOUS REDUCTION IN THE QUALITY OF MEDICAL CARE. THEY POINT OUT THAT DOCTORS MAY ACTUALLY BE ENCOURAGED TO REDUCE TIME SPENT ON EACH PATIENT AND ORGANIZATIONS MAY SEEK TO MAXIMIZE PROFITS BY EXPANDING ENROLLMENT BEYOND THE HMO'S CAPACITY. EXPERIENCE IN GREAT BRITAIN, HOLLAND AND WITHIN THE UNITED STATES IN SOME OF THE LARGER PLANS, LIKE THE KAISER GROUP IN CALIFORNIA, PROVIDE CONVINCING EVIDENCE OF THE DANGERS TO QUALITY CARE.

IN FACT, THE SERIOUS DIFFICULTIES FACED BY HMO STYLE PLANS HAVE BEEN VOICED FROM UNEXPECTED QUARTERS. DR. SIDNEY GARFIELD, THE FOUNDER OF THE KAISER-PERMANTE GROUP, WHICH HAS BEEN PRAISED AS THE MOST EFFECTIVE HMO EXPERIMENT, OBSERVED RECENTLY THAT THE ELIMINATION OF OUT-OF-POCKET EXPENSES MAY CREATEUNREASONABLE DEMAND WHICH IS IMPOSSIBLE TO ADEQUATELY SERVICE. IN DESCRIBING THE KAISER EXPERIENCE, HE NOTED THAT "AN UNCONTROLLED FLOOD OF WELL, WORRIED-WELL, EARLY-SICK, AND SICK PEOPLE" CONVERGED UPON THE HMO INTAKE POINT -- THE DOCTOR'S OFFICE. ALL WERE TREATED ON A FIRST-COME, FIRST-SERVED BASIS THAT HAD LITTLE RELATION TO PRIORITY OF NEED.

IN LIGHT OF THIS WARNING AND EVIDENCE OF MIXED SUCCESS, THIS YEAR'S HMO BILL SEEMS TO ME A PRAGMATIC AND PRUDENT APPROACH. INSTEAD OF LOCKING US INTO A NATION-WIDE NETWORK OF LARGE-SCALE HMO'S AS THE ORIGINAL PLAN PROPOSED, THE BILL WHICH PASSED WITH SUPPORT FROM THE ADMINISTRATION WOULD BUILD ON A VARIETY OF GROUP PRACTICE AND HMO-STYLE OPERATIONS TO DEVELOP AND TEST THE HMO CONCEPT. HEW, WHICH WILL SUPERVISE THE PROGRAM, HAS ALREADY DONE SOME EXPERIMENTING WITH ALTERNATE MODES OF HEALTH CARE DELIVERY AND SHOULD THEREFORE BE ABLE TO DESIGN HMO STUDIES WITH ADEQUATE CONTROLS AND COMPREHENSIVE DATA.

THIS FIRST STEP IS A VITAL ONE FOR ANOTHER REASON, TOO -- REFINING AND IMPROVING THE ORIGINAL CONCEPT THROUGH CONTROLLED EXPERIMENTATION MAY WELL PROVE TO BE THE KEY TO ITS SUCCESS. NO ONE IS READY TO SCRAP OUR ENTIRE HEALTH CARE SYSTEM, WHICH IS DIVERSE AND LOCAL IN CHARACTER, FOR ONE MODE OF DELIVERY, ESPECIALLY AN UNPROVEN ONE. SO WE MUST WORK WITH WHAT WE HAVE AND CAREFULLY INTEGRATE WITHIN IT NEW METHODS OF DELIVERY WHICH WILL NOT PROVE DISRUPTIVE IN THE LONG-RUN.

ALTHOUGH THE HMO CONCEPT ATTACKS HEALTH CARE FROM BOTH SIDES -- FINANCING AND DELIVERY -- FEW EXPECT IT TO STAND ALONE NOW OR IN THE FUTURE. HIGH COSTS, THOUGH STEMMED, WILL NEVER BE LOW AGAIN AND PRIVATE INSURERS HESITATE TO EXTEND THEIR COVERAGE TO MEDICAL EXPENSES WHICH BURDEN CONSUMERS MOST SEVERELY RIGHT NOW. SO THERE ARE OTHER NECESSARY MEASURES AWAITING CONGRESSIONAL ACTION. PLANS FOR CATASTROPHIC ILLNESS INSURANCE ARE NOW PENDING IN THE HOUSE AND SENATE. THESE PROPOSALS ARE DESIGNED TO MEET THE NEEDS OF THOSE WHO SUFFER FROM LOOPHOLES IN PRIVATE INSURANCE COVERAGE, MIDDLE-INCOME PATIENTS WITH PROTRACTED ILLNESSES. THESE PATIENTS ARE ALMOST COMPLETELY COVERED FOR THE COSTS OF THE FIRST FEW HOSPITAL DAYS, BUT WHEN THEIR HOSPITAL STAY EXTENDS BEYOND DAYS TO WEEKS AND MONTHS, PRIVATE HEALTH INSURANCE COVERAGE OFTEN BREAKS DOWN AND SOMETIMES, AS A RESULT, PATIENTS FACE THE POSSIBILITY OF BANKRUPTCY.

OTHER FACTORS MAKE THIS PROBLEM IMPOSSIBLE TO HANDLE WITHIN THE CURRENT SYSTEM OF PRIVATE FINANCING. HEALTH INSURANCE COMPANIES ARE UNWILLING TO COVER THE VIRTUALLY UNLIMITED HOSPITAL STAYS ASSOCIATED WITH CATASTROPHIC ILLNESSES FOR GOOD REASONS OF THEIR OWN. THEY TOO COULD BE BACKRUPTED BY THE FINANCIAL BURDEN. CONTRARY TO POPULAR BELIEF, HEALTH INSURANCE IS AN UNPROFITABLE BUSINESS. IN 1969, PRIVATE HEALTH INSURANCE SHOWED A NET UNDERWRITING LOSS OF 3.7 PERCENT. PROFITS FROM OTHER FORMS OF INSURANCE HAD TO BE DRAWN UPON TO FINANCE HEALTH INSURANCE CLAIMS.

CONGRESS, HAS THEREFORE BEGUN TO CONSIDER THE POSSIBILITY OF FILLING THIS GAP WITH A FEDERAL INSURANCE PROGRAM. THE HOUSE BILL IS A CATASTROPHIC COVERAGE PLAN WHICH WOULD ESTABLISH A PROGRAM OF VOLUNTARY PRIVATE

HEALTH INSURANCE ALLOWING FEDERAL FUNDS FOR MEDICAL EXPENSES ABOVE A CERTAIN PER-PATIENT LIMIT. THE SENATE APPROACH USED THE MEDICARE PROGRAM AS ITS FUNDING VEHICLE BUT BASICALLY SHARES THE SAME GOAL OF DEFRAYING EXORBITANT LONG-TERM EXPENSES.

A MORE COMPREHENSIVE APPROACH WHICH WOULD LINK FINANCING WITH CONTROLS AND INCENTIVES IS CONTAINED IN SEVERAL DIFFERENT NATIONAL HEALTH INSURANCE PLANS WHICH ARE ALSO RECEIVING ATTENTION IN CONGRESS. CONGRESS IS AGAIN POSED WITH THE PROBLEM OF SORTING THROUGH WHOLESALE, HIGH-RISK APPROACHES AND DESIGNING INSTEAD EXPERIMENTAL MEASURES. IT IS EXPECIALLY VITAL THAT ANY COMPREHENSIVE FINANCING MECHANISM BE CLOSELY EXAMINED IN PRACTICE BEFORE WE EMBARK UPON A COURSE WITH FORESEEN CONSEQUENCES. THE EFFECTS OF PRESENT FINANCING PRACTICES -- MEDICARE, MEDICAID AND PRIVATE HEALTH INSURANCE -- HAVE BY NO MEANS BEEN ADEQUATELY EXPLAINED, BUT WE DO KNOW THAT UNCONTROLLED THIRD-PARTY PAYMENTS HAVE HAD SERIOUS INFLATIONARY RESULTS IN THE HEALTH CARE SECTOR.

THUS, NATIONAL HEALTH INSURANCE PLANS MUST AVOID OLD PITFALLS THROUGH EFFECTIVE COORDINATION WITH ORGANIZED MODES OF HEALTH CARE DELIVERY AND A SET OF ADEQUATE ECONOMIC CONTROLS AND INCENTIVES. ONE APPROACH TO NATIONAL HEALTH INSURANCE IS CURRENTLY UNDER STUDY BY THE ADMINISTRATION. THE DEPARTMENT OF HEALTH, EDUCATION AND WELFARE HAS JUST COMPLETED A REVISION OF THE ORIGINAL ADMINISTRATION PROPOSAL WHICH HAD APPEARED TO HAVE SOME SERIOUS DEFICIENCIES AND LARGE GAPS LAST YEAR WHEN IT WAS DISCUSSED ON CAPITOL HILL. THE NEW VERSION HAS BEEN SUBMITTED TO THE WHITE HOUSE BY HEW FOR APPROVAL AND CHANGES. ALTHOUGH THE HOUSE WAYS AND MEANS COMMITTEE EXPECTED THE ADMINISTRATION TO PROVIDE THE COMMITTEE WITH THE PROPOSED PLAN

BEFORE THE END OF LAST MONTH, IT IS NOW APPARENT THAT THE ADMINISTRATION WILL DELAY SENDING IT TO THE COMMITTEE PENDING FURTHER STUDY AND REFINEMENT. SINCE THE WAYS AND MEANS COMMITTEE MAY WELL BE SWAMPED IN OTHER LEGISLATIVE BUSINESS THIS WINTER, IT IS DOUBTFUL THAT ANY SIGNIFICANT ACTION ON A NATIONAL HEALTH INSURANCE PLAN WILL TAKE PLACE IN THE NEAR FUTURE.

ALTHOUGH THE NEW VERSION OF THE ADMINISTRATION'S PROPOSAL HAS NOT YET BEEN EXAMINED IN CONGRESS, ITS OUTLINES ARE CLEAR. THE PLAN IS DIVIDED INTO TWO SEGMENTS. A LARGER ONE, PAID FOR BY WORKERS AND EMPLOYERS TOGETHER, KNOWN AS THE STANDARD EMPLOYER PLAN, WOULD COVER AN ESTIMATED 39 MILLION FAMILIES AND AN UNDETERMINED NUMBER OF SINGLE INDIVIDUALS AND CHILDLESS COUPLES. THE SMALLER SUBSIDIZED PLAN, CALLED THE GOVERNMENT ASSURANCE PROGRAM, WOULD AID THE POOR AND PERSONS WITH UNUSUALLY HIGH HEALTH RISKS. MEDICARE WOULD CONTINUE TO COVER THE ELDERLY AND THE TWO NEW PLANS WOULD OPERATE THROUGH CONVENTIONAL INSURANCE CHANNELS, BLUE CROSS, BLUE SHIELD, OR OTHER COMMERCIAL COMPANIES. BENEFITS IN BOTH PLANS WOULD COVER AREAS PREVIOUSLY UNINSURED -- PAYMENTS FOR PRESCRIPTION DRUGS, MENTAL ILLNESS, SKILLED NURSING, HOME HEALTH CARE, AND SOME DENTAL SERVICES.

MANY OF THIS YEAR'S CHANGES IN THE PLAN WILL MAKE IT MORE ATTRACTIVE TO ITS FORMER CRITICS. MORE FEDERAL FUNDING IS EXPECTED, COVERAGE HAS BEEN BROADENED BEYOND THE ORIGINAL FAMILY PLAN TO INCLUDE SINGLE INDIVIDUALS AND COUPLES, CERTAIN QUALITY GUIDELINES HAVE BEEN ADDED TO THE GOVERNMENT-SUBSIDIZED PROGRAM FOR THE POOR, AND HEW HAS TRIED TO TIGHTEN COST CONTROLS.

HOWEVER, THE WHITE HOUSE HAS NOT OFFICIALLY ANNOUNCED THESE CHANGES, SO IT'S DIFFICULT TO TELL FOR CERTAIN AT THESE PRELIMINARY STAGES WHETHER

OR NOT THE PLAN WILL BE A WORKABLE ONE. ITS MAIN ADVANTAGE, IN MY VIEW, IS THAT IT ATTEMPTS TO LAUNCH THE FEDERAL GOVERNMENT INTO THE AREA OF HEALTH INSURANCE IN A LIMITED WAY INSTEAD OF BREAKING HEADLONG INTO THE INSURANCE FIELD WITH AN ALL-OUT COMPULSORY NATIONAL HEALTH INSURANCE PROGRAM. SOME OF THE MORE FAR-REACHING PLANS WHICH ARE NOW BEING AIRED IN CONGRESS SHOW WHAT I CONSIDER TO BE LACK OF CAUTION IN THE EXTREME FOR THEY PROPOSE TO CHARGE INTO THE ALMOST UNEXPLORED FIELD OF HEALTH INSURANCE WITH QUICK SOLUTIONS WHICH EVEN THE MOST RESPECTED HEALTH EXPERTS HAVE NOT BEEN ABLE TO REACH AGREEMENT UPON.

ALTHOUGH I HAVE CAUTIONED TONIGHT AGAINST HASTY ACTION, I WOULD LIKE IN THIS INSTANCE (IN THE CASE OF NATIONAL HEALTH INSURANCE) TO QUALIFY MY APPROVAL OF THE CURRENT "GO-SLOW" APPROACH TO HEALTH CARE LEGISLATION. SOME OF THE RECENT DELAY SIMPLY CANNOT BE JUSTIFIED. IN MANY INSTANCES, IT HAS REFLECTED A LACK OF ADEQUATE CONCERN FOR THE NATION'S HEALTH CARE NEEDS. I FEAR THAT HEALTH MAY BE SLIPPING TO THE BOTTOM RUNGS OF THE PRIORITY LADDER, AS ENERGY PROBLEMS, TRADE LEGISLATION, DOMESTIC EVENTS, AND INTERNATIONAL TURMOIL CLIMB TO THE TOP.

FOR THIS REASON I WOULD URGE THAT THE NATIONAL HEALTH INSURANCE PLAN STILL BEING REWORKED BY THE ADMINISTRATION BE PRESSED TO COMPLETION AND PROMPTLY CONSIDERED IN CONGRESS. WE MUST MOVE FORWARD NOW TO FINALLY REORGANIZE OUR HEALTH CARE SECTOR IN A REASONABLE FASHION. IT IS MY OPINION THAT A LIMITED FORM OF NATIONAL HEALTH INSURANCE WILL PLAY A VITAL ROLE IN THIS NECESSARY PROCESS.

THE GOAL OF COMPREHENSIVE HEALTH CARE FOR ALL AMERICANS IS PRESSING AND URGENT. IT DESERVES OUR SERIOUS ATTENTION AND CONCERN. HOWEVER, I WOULD LIKE TO STRESS ONCE MORE THE NEED FOR A CAUTIOUS AND BALANCED APPROACH, FOR THE FORM OUR ATTENTION TAKES -- HASTY RESPONSE OR GRADUAL IMPLEMENTATION

IS NOT ONLY OF INTRINSIC IMPORTANCE, BUT COULD WELL DETERMINE WHETHER THE GOAL ITSELF IS EVER REACHED. THE CAREFUL PLANNING OF A NATIONAL HEALTH CARE POLICY IS INDEED THE ONLY WAY TO GUARANTEE EVERY AMERICAN'S "RIGHT TO HEALTH."